SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Request for PDD Waiver Slot Allocation: Cover Sheet

Section 1: Participant Information **Date: _____**

Name of Participant:	Social Security Number:
Address:	Medicaid #:
	If none, has application been made? □ Yes □ No
Date of Birth:	□ Male □ Female
Parent/ Legal Guardian Name:	
□ Autism □ Asperger's Syndrome □ Other PDD (specify)	
□ Eligible □ Eligibility Pending □ Time Limited	

Section 2: Provider Information:

SC/EI:	Provider:
Address:	
SC/EI Supervisor:	County:

Section 3: Other Waiver Information:

Is the participant in any other Medicaid Waiver? □ Yes □ No

If yes: Name of Waiver:

My signature here indicates my understanding that I can participate in no more than one waiver at any given time. Therefore, I wish to participate in the: MR/RD Waiver □ PDD Waiver □

Parent Signature: **Date:**

Type and amount of services received:

Section 4: Family Support Information:

Is the participant receiving ongoing family support funds through DDSN? □ Yes □ No

If yes: What is the amount of funding and type of service received per month?

Section 5: Indicate specifically how Early Intensive Behavioral Intervention will assist the consumer and prevent the need for institutional placement. Include specific information regarding the consumer's behaviors.

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The following information/documents must be attached to this application:

All information necessary for initial LOC

*SC/ EI Supervisor signature confirms all necessary information is attached.

SC/ EI Signature Date SC/ EI Supervisor Date